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Job satisfaction and dissatisfaction of primary health care professionals

Satisfação e insatisfação no trabalho de profissionais de saúde da atenção básica

Satisfacción e insatisfacción en el trabajo de profesionales de salud en atención básica

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Abstract

Objective: Qualitative research aimed to identify the reasons for the satisfaction and dissatisfaction of health care professionals in the Family Health Strategy (FHS) and Traditional Primary Care (TPC). **Methods:** It was including 22 health professionals from southern Brazil. The data was collected through interviews and focus groups. **Results:** The main reasons for the satisfaction in the two models were found to be the professional-affinity/enjoying their job and the patient's satisfaction, teamwork experience. In regards to the FHS' it was mentioned the bond between professionals and patients/users. The main reasons for the dissatisfaction were due to problems in the relationship with users/families. In the TPC were highlighted underpaid and the difficulties in teamwork. In the FHS were mentioned deficits in the work instruments and in the work environment, excessive working hours and lack of understanding of the model. **Conclusion:** The subjective dimension influences job satisfaction, but the work conditions are strongly significant.

Keywords: Occupational Health; Primary Health Care; Family Health; Job Satisfaction.

Resumo

O objetivo desta pesquisa qualitativa foi identificar motivos de satisfação e insatisfação dos profissionais de saúde em dois modelos assistenciais, na Estratégia de Saúde da Família (ESF) e na Atenção Básica Tradicional (ABT). **Métodos:** Amostra intencional com 22 profissionais de saúde do sul do Brasil e dados coletados por meio de entrevistas e grupo focal. **Resultados:** Principais motivos de satisfação: nos dois modelos - afinidade com a profissão/gostar do que faz, satisfação dos usuários com a assistência recebida, trabalho em equipe; na ESF- vínculo entre profissionais e usuários. Principais motivos de insatisfação: nos dois modelos - problemas nas relações com usuários/famílias; na ABT- salário insuficiente e dificuldades no trabalho em equipe; na ESF - déficit nos instrumentos e ambiente de trabalho, carga horária excessiva e falta de compreensão sobre o modelo. **Conclusão:** A dimensão subjetiva influencia a satisfação laboral, mas condições concretas para a realização do trabalho são fortemente significativas.

Palavras-chave: Saúde do trabalhador; Atenção primária à saúde; Saúde da família; Satisfação no emprego.

Resumen

Objetivo: Investigación cualitativa que identificó las razones de satisfacción e insatisfacción de los profesionales de salud en la Estrategia de Salud Familiar (ESF) y la Atención Básica Tradicional (ABT). **Métodos:** La muestra fue intencional, con 22 profesionales del sur de Brasil, los datos fueron recolectados con entrevistas y grupos focales. **Resultados:** Las principales razones de satisfacción en los dos modelos: afinidad con la profesión/gustar de lo que hace, satisfacción de los usuarios con la atención recibida, trabajo en equipo. ESF: vínculo profesionales-usuarios. Principales razones de insatisfacción en ambos modelos: problemas en la relación con usuarios-familias. ABT: salarios bajos y dificultades en el trabajo en equipo. ESF: ambiente de trabajo inadecuado, carga laboral excesiva y falta de comprensión del modelo. **Conclusión:** La dimensión subjetiva influye en la satisfacción laboral, pero las condiciones de trabajo son fuertemente significativas.

Palabras-clave: Salud Laboral; Atención Primaria de Salud; Salud de la Familia; Satisfacción Laboral.

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INTRODUCTION

In the current scenario of Brazilian health post Constitution of 1988, there are initiatives to strengthen primary health care and health services reorganization in order to approach the constitutional principles and to the established in the Organic Health Law, Law 8080 and Law 8142 of 1990. In the Brazilian primary care coexists two social models understood as non-material technologies concerning the organization of work in health care: A model predominantly guided by the standards of biomedicine, centered on medical care for the diagnosis and treatment of diseases - the Traditional Primary Care (TPC); and another designed as innovative in the sense of approximation to the principles and guidelines of the Unique Health System (UHS)-a Family Health Strategy (FHS).

The FHS proposes a change of perspective in care, to organize work and to understand the health-disease process. It focuses on collectivities and proposes to care for the individual considering the comprehensiveness, each person as part of a family and social context. It aggregates curative, preventive actions and actions of health promotion. This model also provides the analysis and the monitoring of health problems, taking into account the epidemiological and health indicators. It proposes the development of actions that meet the demands of the population, promoting access to health services, improving the quality of preventive and curative actions and ensuring more appropriate care[1-3].

The two existing models in the primary care have distinct challenges and originate different demands with consequent implications on job satisfaction of the teams. When working, human beings do not only use their knowledge and skills. In the labor process the individual as a whole is mobilized and turns in the process. According to Dejours[4:27], the work

> *[...] is what implies the human point of view, the fact of work including know-do, an engagement of the body, the mobilization of intelligence, the ability to reflect, interpret and react to situations; is the power of feeling, thinking and inventing. [...] Just keep working, is not only to produce it is also transforming itself [...].*

To work involves relationships, which can result in satisfaction or can cause suffering. The work in the health sector is a special work caring for human beings and developed, mainly in the form of collective work. A work of this kind implies relationships between professionals and users of the services and their families, as well as to work in health care implies relationships among the participants of the teams and between professionals and managers[5,6].

In the literature, we can find studies addressed, directly or indirectly, to satisfaction and dissatisfaction at work in health care[5,7,8], however studies about job satisfaction in the primary care are rare[9,10], as well as there are not studies analyzing this phenomenon in health professionals who work in the two primary care models existing in Brazil - the traditional based on biomedicine and the innovative model of the FHS. Satisfaction and dissatisfaction at work in health care have implications on the health of professionals and on the results of care provided by the health care services. Happier individuals have better quality of life and lower rates of physical and mental illness. Satisfaction and dissatisfaction at work influence the behavior of worker[8], with implications for the process of sickness, accidents at work, in the absences to work, in the errors and in the safety of users[7].

The satisfaction can be understood as a pleasurable emotional state resulting from multiple aspects of the work and which can be influenced by the values, the aspirations, experiences and individual characteristics of each worker, resulting in differentiated ways of confronting problems and in the everyday making decision[6]. In this scenario was designed to present research in order to identify sources of satisfaction and dissatisfaction in the work of health professionals who work in two care models existing in primary care in Brazil - the FHS and the TPC.

METHODOLOGY

Study of qualitative nature, sustained by the theory of labour process in health care, and by the approach of Dejours[4] about pleasure and suffering at work. It was carried out in the 7th Health Regional (HR), located in the Southwest of the Paraná state, including three FHS teams and three of TPC.

For the composition of the population of study it was used the following criteria: choose typical teams of each model (TPC and FHS) indicated by the Coordinator of the Health Regional performing a good job; to include only health professionals in equal number on both care models; to include only FHS teams with the complete minimum team and professionals with a minimum of one year of performance in the teams. Mixed units were excluded (with presence of the two care models in the same institution).

The total of the research participants was 22 professionals, being 11 from the FHS - three physicians (P), three nurses (N), three nursing technicians (NT), a dentist (D) and a technician in dental hygiene (TDH), and 11 professionals from TPC, in number and professional category equal to the FHS.

For data collection it was used interviews and focus groups. The interviews were conducted with health care professionals of the selected and representative teams of the two care models, seeking: a) information relating to the work of health professionals; b) identify the composition of the team and the characterization of the care practices directed at users/patients; c) identify the organization and division of labor on the team; d) identify the motives of satisfaction and dissatisfaction at work on both care models. Considering the objective of this study, it was requested to each professional interviewed, to list in order of priority, three motives of satisfaction and dissatisfaction at work. The interviews were

taped and later transcribed. The findings obtained in the interviews were organized and presented for discussion and validation on focus group sessions - three sessions in each care model.

To data analysis was used the qualitative data analysis software, ATLAS.ti 7.0 (Qualitative Research and Solutions). All the interviews were transcribed and also the data obtained in the focus group sessions. Each document was included in the Atlas.ti and coding based on categories considering the objective and the theoretical framework defined for this research. The macro categories of analysis were: job satisfaction and dissatisfaction at work. The speeches of subject has been identified by the designation of professional category and number of order, plus the initials FHS or TPC.

For the development of this research were observed the ethical aspects recommended by resolution 196/96 of the National Health Council and the project was submitted and approved under number 971/2010, by the Committee of Ethics in Research at the Federal University of Santa Catarina.

RESULTS

The results obtained in the interviews with the 22 health professionals (11 of the TPC and 11 of FHS) were organized into 04 categories: motives of satisfaction and dissatisfaction at work in the TPC and motives of satisfaction and dissatisfaction in the FHS.

Reasons of job satisfaction in the Traditional Primary Care (TPC)

The 11 health professionals interviewed in the TPC have cited seven different reasons for job satisfaction listed in Table 1.

Among the reasons for job satisfaction, the affinity with the model of providing care, the affinity with the profession and to like what they do was the most significant.

> *For me, in this case, is because I can give some from me, I can talk, I can help [people]. So, there are certain things that the person comes, and we can talk.* (NT2 TPC)
>
> *Hmm, my job, one that I like my job, I like what I do*.(TDH1 TPC)

The second reason for satisfaction was the resolution of the service offered to the users/patients; user satisfaction with the received care.

> *Resolution, to see that the user/patient problem was solved.* (P1 TPC)
>
> *I believe the resolution. I think when the UHS achieves [...] to improve this issue [...] it will be a step beyond.I think resolution*.(N2 TPC)
>
> [...] *When the patient goes happy we're happy too*. (TDH1 TPC)

Tabela 01. Motives of job satisfaction among health professionals of the TPC

Motives of job satisfaction	Total of quotations	%
Affinity with the job/profession and loving what you do	10	45.45%
Efficacy of the provided care and users/patients satisfaction	04	18.18%
Team work	02	9.09%
Salary	02	9.09%
Practice of user embracement and bond with the users of the service	01	4.54%
Autonomy in conducting the work	01	4.54%
Did not identify a source of satisfaction	02	9.09%
Total	22	100%

The other motives for job satisfaction were: teamwork/team commitment; salary; practice of user embracement and bond with users; autonomy for to do their job. However, two respondents were unable to identify any source of job satisfaction at TPC.

> *Look, today, I don't have any motivation, I have nodesire to-get out of bed [...]. My motivation today is zero. (NT1 TPC)*

Reasons of job satisfaction in the Family Health Strategy (FHS)

In the care model of the FHS were identified eight different reasons of job satisfaction, being that all professionals were pleased with something related to your work (Table 2). The main reason for satisfaction was the resolution of care (the efficacy of care), the second most significant was his work as a team, followed by the affinity with the profession, "to love what you do".

> *The follow-up of the patient, you know what happened to the patient. To know if he get better.* (P1 FHS)
>
> *To see my team can solve the problems, that the population is satisfied with the work of my FH team is a source of satisfaction.* (N3 FHS)
>
> *My team in the first place.* (N1 FHS)
>
> (...) *it is the team, so much that sometimes I think, Oh I'm not going to work in this morning, but then I think, Oh but I will overwhelm my colleagues, so I think I have to come for the team. The team encourages me up to come to work (...)*.(NT2 FHS)

Table 2. Motives of job satisfaction among health professionals of the FHS

Motives of job satisfaction	Total of quotations	%
Satisfaction of the users with received care and their collaboration in the caring process	09	30%
Team work	06	20%
Affinity with the job/profession and loving what you do	05	16.66%
Bond among professionals and between them and users	04	13.33%
Wage	02	6.66%
Dynamic and diversity of activities in the FHS	02	6.66%
Demand, when reduced	01	3.33%
Application of the proposal of the FHS, including intersectoriality	01	3.33%
Total	30	100%

Is the team as a whole. (P3 FHS)

[...] it is the team we participate here. They're my second family. (NT3 FHS)

[...] is to love what I do. (NT2 FHS)

Is because I like it, I did Odontology and I enjoy working, so the motivation is my job. I like my job, that's what I like to do. (D1 FHS)

The second reason is because somehow I am doing a good job, I like what I do. Sometimes I feel like running away from here, but I like...to be auxiliary.

Sometimes I don't like it, but I like my job, how I act in people's lives.(TDH1 FHS)

Fourthly appears the satisfaction by the bond established among the participants of the team and between professionals and users. Bond is markedly important in FHS. The bond is identified in the professional talks about recognition from the population and about confidence in the team.

My population, which receives me very well. (N1 FHS)

It is the relationship with patients and with the team. (NT1 FHS)

The remaining motives of job satisfaction, less mentioned, were: the salary, the commitment of the user/patient, the dynamics and diversity of activities in the FHS, the demand when reduced and the application of the prescribed in the FHS, including the relationships between the health services with the other services and institutions in the community.

Motives of job dissatisfaction in Traditional Primary Care

In relation to dissatisfaction at work, the 11 professionals from the TPC model have mentioned nine reasons of job dissatisfaction. As described in Table 3.

Table 3. Motives of job dissatisfaction among health professionals of the TPC

Motives of job dissatisfaction	Total of quotations	%
Difficulties in relation to the user/family collaboration in the caring process	06	25%
Salary	06	25%
Difficulties in the team work	03	12.5%
Lack of recognition at work and need for professional development	02	8.33%
Shortage of working instruments and poor working environment	02	8.33%
Problems in the management	02	8.33%
Lack of incentives for continuing education	01	4.16%
Excess of demand	01	4.16%
Working hours	01	4.16%
Total	24	100%

Among the reasons for job dissatisfaction, the most significant were: difficulties in relation to users and families collaboration in the caring process; the perceived salary, considered insufficient; and difficulties in teamwork.

What's missing is a greater commitment of users with their health, the family needs to assume their responsibility. (P2 TPC)

What bothers me is the lack of commitment of the user with his/her treatment. (P3 TPC)

But what bothers me here is the salary. About the rest you can't complain if I compare to my other job. (NT3 TPC)

I think it's the lack of collegiality, the lack of commitment of the team.

Sometimes we stay up to until one in the morning typing something and next day you come here, ' Oh no, I can't', you know. (NT1 TPC)

Other reasons for job dissatisfaction mentioned by the professional were: lack of recognition at work and professional devaluation; deficits on the instruments and working environment; problems in the management; lack of incentives for continuing education; excess of demand and excessive working hours.

Reasons for dissatisfaction at work in the Family Health Strategy

The 11 professionals from FHS have mentioned 10 reasons for job dissatisfaction, which are arranged in the Table 4. Among these stood out the deficit in labor instruments and in the structure of the primary care units including the precariousness in the physical area. These conditions were considered inadequate for perform their work.

Table 4. Motives of job dissatisfaction among health professionals of the TPC

Motives of job dissatisfaction	Total of quotations	%
Shortage of working instruments and the poor working environment of the primary care units	07	20.58%
Problems in the relationship with users, including aggression	05	14.70%
Lack of comprehension from the manager, the team and the users of the care model of the FHS	04	11.76%
Excessive working hours	04	11.76%
Salary	03	8.82%
Problems in the teamwork and in training people for teamwork	03	8.82%
Excess of demand	03	8.82%
Problems in the reference and counter-referral system and in technical support	02	5.88%
The centralization of medical care	02	5.88%
Devaluation of public services	01	2.94%
Total	34	100%

> *The structure of my unit [primary care unit] I don't agree [...], let's get the basic plan of the Ministry and you can see what must be a health unit, how should be a room of vaccines. When I came here in my room of vaccines it had no cling film on the window, still using curtain, and that is completely out of reality. I think the infrastructure is the first aspect to give a good service to the population, with privacy, with respect. So we have to put on paper.* (N1 FHS)

> *The lack of materials and the physical structure of the unit, it should be better [...] it's all improvised. Here wouldn't be a unit, is part of a school, it should be larger rooms [...]. In spite of the fact that we're getting a new unit. Those are the things that bother me.*(NT3 FHS)

Among the causes of dissatisfaction mentioned by professionals, was also significant: relationship problems with the user population of the health services and with the managers due to the characteristics of the new care model proposed for the FHS. Interviewed have mentioned that there is "lack of understanding/knowledge" of the population, the managers and the team members about the characteristics of the care model of the FHS.

> *Lack of commitment of the users.* (N2 FHS)

> *I think the first reason is the stress that we have with users and family members who don't know our system of work. Instead to try to dialogue with the team (manifest themselves through) to communications to chief, to Ombudsman's Office, without any attempt at dialogue. This is what creates confusion and discussion in here.*(P2 FHS)

> *[...] and the difficulty of understanding from other services with respect to our service.(N*3 FHS)

It showed, several other issues related to working conditions as: excessive working hours, low aspects are sources of dissatisfaction and increased workloads in FHS, leading to attrition of workers.

> *There is a lot of demand causing risks.(*P2 FHS)

> *[...] most who works here just use it as a "moonlight" job, because it's not well-paid, is very badly paid*. (P3 FHS*[...] most who works here just use it as a "moonlight" job, because it's not well-paid, is very badly paid*. (P3 FHS)

> *I see that the working hours are heavy increasing workloads. We get out here very tired because there are a lot of people, a lot of contact. The demand is too much.* (TDH1 FHS)

The difficulty to effective teamwork and the lack of investment in vocational training, to carry out an integrated and collaborative work were proved as dissatisfaction sources for survey´s respondents.

> *The team has just two years. The team is very new, so we're helping them to work respecting the characteristics of the FHS [...]. There is lack of training to perform their job as an effective teamwork.* (P2 FHS)

The health network reveals weaknesses resulting in difficulties to do a good job and also causing professional dissatisfaction. The participants of the research have still mentioned the lack of recognition of work developed by FHS.

A second point is the return of the information [...] what was said by the doctor from the other service (hospital for example). Because we could work better with the patient if we knew what was done there. There are problems in reference and counter-referral system. (N3 FHS)

You need the PAC [Psychosocial Attention Center], the firefighters, the police, various sectors but this relationship fails. There is not a support, an integrated system to care for the user. (N1 FHS)

The heavy is because the users ask for more despite we try to do a good job with a good quality. They think that because it is public there is not quality. That bothers me. (TDH1 FHS)

DISCUSSION

The research results showed that, regardless of the care model (TPC or FHS) job satisfaction is strongly influenced by three factors: to perform a job which they have affinity, "to love what you do"; the efficacy of the provided care, which in the case of health has a strong relationship with users' satisfaction; and thirdly the teamwork. In the FHS, in addition to the three motives of satisfaction listed, the professionals have mentioned the bond among the team members and with the users.

As regards motives for job satisfaction, two of the most significant, "to love what you do" and realize that the product of their work is useful to society and recognized by users are supported by the theorization of Dejours[4] and Marx[11] about human labor. According to Marxist theory, in the human labor occurs a process of transformation creating products to meet needs. In a philosophical perspective, this author says that the labour process consists of a creative process, in which the worker finds himself in the product of their work[11]. In the transformation process, the worker mobilizes not only his body and his cognitive ability, but his emotions, their expectations - the subject in its entirety is involved in the action[4,11]. "To love what you do" has this relationship with the work, to feel itself as part of the process and not just executer of delegated tasks performed so alienated. The worker can realize his magic touch in the transformation process. "To love what you do" is protective for the employee, contributing to achievement of a purpose-driven work designed for each work activity.

Teamwork was the third most significant reason for job satisfaction on TPC and the second on FHS. This result indicates the positive effect of teamwork on the worker in any care model. When the work is done in teams collaboratively with shared objectives, and sum of efforts for the collective result, increases the effectiveness of care and contribute to greater job satisfaction. This finding approaches to the literature with regard to work in team, and in health teams[6,12,13]. As regards the FHS, it seems that the model prescribed by the Brazilian Ministry of Health has contributed positively to the viability of cooperative teams, to prescribe that the care people living in defined geographical area should be performed by multi professional teams cooperatively and in an interdisciplinary perspective[2].

With regard to dissatisfaction at work, it was found, in two models, the main reasons for dissatisfaction are: relationships difficulties; difficulties in collaboration of users, families and community in the caring process; difficulties in the relationships to the achievement of teamwork; and deficits in working conditions - salary and working hours. The deficits in the work tools/instruments, environment and physical area were more significant for job dissatisfaction in the FHS. These findings are consistent with the literature about the work process, in particular on health[5,14-16].

As regards the relationships with users, family and community, but also with colleagues and managers seems that problems in this field are significant for dissatisfaction at work independent of the care model - TPC or FHS. Health care depends on a multidisciplinary collective work that to his effective feasibility depends on the cooperation and good relationships among the team members and between them and the subject of care/service users[16]. Labor relations that are established in the teams and with the users have a subjective and cultural dimension and interfere in the outcome and satisfaction of both. Users, families and community dissatisfied can provoke protest reactions, claims and even "aggression" and resistance to accept the prescribed treatments. Dissatisfaction of users influences dissatisfaction of professionals and teams. Seems to be along the same lines, the satisfaction mentioned by the FHS professionals, when they can apply in practice the principles prescribed in the model. The professionals believe in the model proposed for the FHS and identify as a source of dissatisfaction when there are problems in their implementation due to difficulties of understanding by managers, users and team members. In this sense, it is a source of dissatisfaction when they identify the centrality in medical consultations, which approaches to the curative model of biomedicine; as well as when they face to problems in healthcare network (including the reference and counter-referral system). The literature records the various problems that the FHS has faced in their development process and search for consolidation[14,15].

In two models, the working conditions were one of the main reasons for dissatisfaction at work[16]. Working conditions include: deficits in working tools and the environment/physical area; low salaries and excessive working hours; excess of demand related to personal sizing. These problems can be connected with the centrality in the medical complaint-consultation; and the lack of investment in continuing education. It is significant in the literature studies that mention the relationship among dissatisfaction, increased of workloads and poor working conditions[5-9,14,15]. The feasibility of an innovative proposal, such as the FHS depends on working conditions including teams in quantity and quality[15]; fair wages and proper working day; continuing education; management model and work organization more horizontal and

participatory; work instruments in quantity and quality, in order to provide effective and safe care for users and professionals. The deficit on the instruments and physical area was the main reason of dissatisfaction in the FHS. The inadequacy and precariousness of the physical area of the primary care units (PCU) were recognized by the Brazilian Government. The President of the Republic announced, in November 2011, the investment for modernization of 40 thousand PCU and for the construction of 3,000 new PCU in high-risk social areas.

The care model of TPC is based on the positivist science, which has influenced the practice and the organization of health services throughout the world. Even after more than[17] years of implementing a new care model in Brazil, which was formulated to attend the constitutional principles and the principles of the UHS, the two models coexist. The findings of this survey indicate that there is still certain affinity of health professionals and users/patients with traditional curative care, focused in sickness and in medical consultation, and that this model has influenced the FHS teams. However, relating to this finding, a survey conducted by Fertonanni 17 with users of FHS found opposite results regarding what is expected/desired by the users. In that survey, the users have demonstrated to desire caring that approach the principles of comprehensiveness and distant from the model focused on the diseases that orients the TPC. These considerations signal the need for further investigation into this theme. At the same time the results of this research showed that the professionals who work on TPC have mentioned among the sources of satisfaction, innovative aspects strongly valued at FHS, as teamwork, the practice of user embracement and the bond. Other studies[3,18] also have emphasized the importance of these tools to break with the model of "medical complaint-consult" and their positive influence on relationships between professionals and users, which may benefit the satisfaction of both.

The growth of the FHS has brought to the centrality of the debate the need to strengthen strategies to improve the access to health services, the user embracement and the bond between professionals and users which are established on the principles of the UHS. At the same time, the expansion of the FHS has been demonstrating the inadequacy of current organizational arrangements, management model and professional practices to promote a break with the traditional health care model[9].

It is worth mentioning that the work may involve suffering manifested as lack of motivation and apathy[4] and that the absence of sources of job satisfaction, as well as in situations where the remuneration is the only factor mobilizer for the job, the tendency is to conduct the wear and the disease.

FINAL CONSIDERATIONS

The analysis of the reasons of satisfaction and dissatisfaction on the job in primary health care in Brazil signals that "to love what you do", working conditions and labor relations has a strong implication in the determination of the two situations. The study showed that although there is a subjective dimension in job satisfaction, the concrete conditions for the realization of the work are strongly significant. The survey also reaffirmed the existence of macro problems on the health network which weaken the primary health care and the Brazilian UHS. These problems are structural, political, cultural and due to the deficit of financial investment, signaling a long and difficult path to be trodden.

The research findings also indicate the immediate need for investments in qualifying teams and managers, as well as in strengthening the mechanisms of social control and stimulating the health teams perform their job guided by the commitment to the health of the users. However, it is crucial to consider the need of caring and valorization of the worker of the UHS, investing on better wages, on the implementation of a plan of carrier in the UHS, on professional education, on strengthening the multidisciplinary collective work in interdisciplinary perspective and on intersectional activities aiming to solve the problems on the healthcare network. These investments help to improve professionals and users satisfaction.

The results of this study contribute to the debate about care model, health of healthcare workers and the effectiveness of the healthcare services. It has limitations with regard to generalization especially due to the design of the research which is an in depth of a specific reality. More studies in this field can subsidize changes but also can reinforce the good results with a view to strengthening of the UHS.

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